Methodology.– If the concept takes shape and is supported by "Trajectoire" tool, it would be however too simplified to reduce the function to the tool. According to the Larousse dictionary, "to conceptualize is defined as raising empirical practices on the level of the concept".
We have thus proposed a concept in three dimensions:
– a vertical dimension or approach by sector: the course of ideal health care;
– an horizontal dimension or territorial approach: characterization of the resources;
– a temporal dimension or approach which takes into account the factors of time, taking responsibility of, reactivity time, blocking time...
Discussion-conclusion.– This design is supported by eleven years of practice since 2001. This reflection "... can generate method, knowing that "the method, it is what one discovers afterwards". (Gaston Bachelard)". From this concept, it seems to us that the action of coordination can be more easily put forth, in a territorial and regional dynamic.

http://dx.doi.org/10.1016/j.rehab.2013.07.694

CO54-003-e

CSARR coding of rehabilitation-readaptation acts in three SSR Clinalliance clinics. Six-month experiment

P. Meyer [a], T. Roditis [b,*], M.K. Stenek [a]
[a] *Clinalliance Pierrefitte-sur-Seine, soins de suite et réadaptation neurologique, 32, avenue Victor-Hugo, 93380 Pierrefitte-sur-Seine, France*
[b] *Groupe Clinalliance CRF Villiers-sur-Orge, France*
*Corresponding author.
E-mail address: patrice2meyer@gmail.com

Keywords: CSARR nomenclature; Catalog of rehabilitation and readaptation acts; Notion of global act; CCAM (common classification of medical acts); IVA (indicator of activity value); PMSI (Program for medicalization of information systems); ICF; Common language
We present our statistics and our coding experience of CSARR (catalog of rehabilitation and readaptation acts) in neurorehabilitation, EVC-EPR, orthopaedics, geriatrics and cardiology, along with some protocol examples. A quantitative comparative between CDARR and CSARR reveals a similar increase of the IVA value (indicator of activity value) with a decrease of two-third of declared acts.
The CSARR nomenclature, which codes PMSI (Program for medicalization of information systems) rehabilitation acts and will be mandatory on July 1, 2013, borrows from the CCAM (common classification of medical acts) in regard to the change towards T2A SSR tariffs announced for 2016. The CSARR introduces the notion of global act and is characterized by an appliance-depending classification, a medical wording accessible to professionals, a significant part dedicated to orthoses, more collective acts and a chapter dedicated to therapeutic education. Part of the wording describes the entire performing of an act, enumerating the main elementary tasks. Modulators characterize the patient and/or the localisation of the performance. Operators (prepositions, conjunctions, phrases, punctuation signs), conventional symbols (brackets, parentheses) and notes define reading and coding rules thoroughly. The concept of the wording construction refers to the pre-norm prEN 1828 of CEN and to functions described in International Classification of Functioning, Disability and Health (ICF) and it never refers to a particular healthcare professional.
Experiment feedback exposes the advantages of CSARR which describes better the course of rehabilitation acts. Prescription is more intuitive, which suits better current practice standards. Therefore, protocol-making and traceability are easier. A common language makes exchanges between PMR, paramedics and DIM in charge of PMSI easier.
The downsides are the complexity of the coding, the vagueness regarding the obligation to perform all elementary acts, non-described situations, the restriction forbidding the coding by two professionals or the dividing of clinical results, overabundance of acts in ergotherapy, overlapping of acts, and the software editor's delay.
A workgroup set up at the ATIH (technical agency for hospitalization information) will allow CSARR users' observations to be responded to: classifying development, errors correction, integration to the regrouping in GME.

http://dx.doi.org/10.1016/j.rehab.2013.07.695

CO54-004-e

Prospective payment system in post-acute care: Impasse or opportunity for reform?

J.P. Devailly [a,*], L. Josse [b]
[a] *CHU Bichat-Claude-Bernard, Assistance Publique–Hôpitaux de Paris, 46, rue Henri-Huchard, service de médecine physique et de réadaptation, 75018 Paris, France*
[b] *Hôpital Rothschild, Assistance Publique–Hôpitaux de Paris, France*
*Corresponding author.
E-mail address: jpdevailly@gmail.com

Keywords: Rehabilitation; Post-acute care; Prospective payment system; Case-mix; Financing
Objectives.– The transition to a prospective payment system (PPS) in french hospital sector of post-acute care (SSR) has been postponed to 2016. Assuming that the current impasse is linked to the construction methodology for the medico-economic groups (GME), the objective of this study is to provide, through analysis of the work of countries involved in the construction of pricing activity in post-acute sector, a method of classifying patients suitable for SSR and in particular the fair valuation of PRM activities.
Methodology.– We analyzed the available foreign works on the Internet concerning the organization and financing of post-acute care. We selected the models developed in the USA, Belgium, Switzerland and Australia. Comparisons with the French system focuses on the health model selected, the identification of rehabilitation in the process of segmentation of activities, capture tool, taking into account outpatient care, construction methodology of patients classification systems and unit payment.
Results.– The classification GME built by French agency for information on hospitalization (ATIH) foreshadows a payment "per case". It does not reflect the different processes of care, but the categories of the 2008 decrees. Foreign models have in common the reference to ICF model, a clear definition of the concept of rehabilitation, a classification whose the first level is the medical purpose of care, and whose classes of patients are based on their needs, identified by a combination of disease and comorbidities, robust indicators of functional limitations, personal and environmental factors. The Australian system includes outpatient. The payment unit seeks a balance between payment per diem weighted by activity, payment per case, and fixed block grant.
Discussion-Conclusion.– The first level of a coherent medico-economic classification in post-acute sector must match the major goals of medical management. Their description as care programs help to formalize clinical objectives for target populations by linking treatment modalities, predictable resources and evidence. A reform of PMSI-SSR must precede the fair valuation of rehabilitation activities. Their specification is complementary to better integrated care pathways.
Further reading
Cour des Comptes: "Les activités de soins de suite et de réadaptation", Rapport - Septembre 2012.
Marie Houssel: "La tarification à la pathologie en SSR", Mémoire ENSP 2003.

http://dx.doi.org/10.1016/j.rehab.2013.07.696

CO54-005-e

Respective contribution of chronic conditions to disability in France: Results from the national disability-health survey

C. Palazzo [a,*], J.F. Ravaud [b], M. Dalichampt [c], L. Trinquart [c], P. Ravaud [c], S. Poiraudeau [a]
[a] *Service de rééducation et réadaptation de l'appareil locomoteur et des pathologies du rachis, hôpital Cochin AP–HP, université Paris Descartes, PRES, 27, rue du Faubourg-Saint-Jacques, 75014 Paris, France*
[b] *Institut fédératif de recherche sur le handicap, Inserm, Paris, France*
[c] *AP–HP, centre d'épidémiologie clinique, hôpital Hôtel-Dieu U738, Inserm,*

Paris, France
*Corresponding author.
E-mail address: clemence.palazzo@cch.aphp.fr

Keywords: Disability; Handicap; Burden of disease; Chronic condition; Attributable fraction; Comorbidity

Objective.– Representative national data on disability are becoming increasingly important in helping policymakers decide on public health strategies. We assessed the respective contribution of chronic health conditions to disability for three age groups (18–40, 40–65, and 65 years old) using data from the 2008–2009 Disability-Health Survey in France.
Methods.– Data on 12 chronic conditions and on disability for 24,682 adults living in households were extracted from the Disability-Health Survey results. A weighting factor was applied to obtain representative estimates for the French population. Disability was defined as at least one restriction in activities of daily living (ADL), severe disability as the inability to perform at least one ADL alone, and self-reported disability as a general feeling of being disabled. To account for comorbidities, we assessed the contribution of each chronic disorder to disability by using the average attributable fraction (AAF).
Findings.– We estimated that 38.8 million people in France (81.7% [95% CI 80.9;82.6]) had a chronic condition: 14.3% (14.0;14.6) considered themselves disabled, 4.6% (4.4;4.9) were restricted in ADL and 1.7% (1.5;1.8) were severely disabled. Musculoskeletal and sensorial impairments contributed the most to self-reported disability (AAF 15.4% and 12.3%). Neurological and musculoskeletal diseases had the largest impact on disability (AAF 17.4% and 16.4%, respectively). Neurological disorders contributed the most to severe disability (AAF 31.0%). Psychiatric diseases contributed the most to disability categories for patients 18–40 years old (AAFs 23.8%–40.3%). Cardiovascular conditions were also among the top four contributors to disability categories (AAFs 8.5%–11.1%).
Conclusions.– Neurological, musculoskeletal, and cardiovascular chronic disorders mainly contribute to disability in France. Psychiatric impairments have a heavy burden for people 18–40 years old. These findings should help policymakers define priorities for health-service delivery in France and perhaps other developed countries.

http://dx.doi.org/10.1016/j.rehab.2013.07.697

CO54-006-e

Severe neurological impairment and problematic emergency recourses: The construction of a non-transferable patient

M. Le Fort [a,*], I. Ville [b], B. Perrouin-Verbe [a]
[a] *Service de médecine physique et de réadaptation neurologique, CHU de Nantes, 85, rue Saint-Jacques, 44093 Nantes cedex 01, France*
[b] *École des Hautes-Études en sciences sociales, Cermes 3, France*
*Corresponding author.
E-mail address: marc.lefort@chu-nantes.fr

Keywords: Healthcare networks; Emergency transfers; Disability; Hospital organization

Objective.– The ministerial circular of June 2004, the 18th, described the "good conditions" of a multidisciplinary organization for neuro-traumatic healthcare networks. Difficulties for an upstream return in case of acute complication during a stay in a PRM department constituted the basis of this study. Some patients' transfers from PRM were not executed in a convenient way. The aim of this study was to determine the causes of these problematic transfers.
Patients and method.– Six severe handicap cases with a history of problematic upstream transfer during an hospitalisation in the neurological PRM department of Nantes' University Hospital (F) between 2006 and 2012: semi-structured interviews, first of the six patients and of their closer family circle, secondly of 16 acute healthcare professionals (emergency medical service and transport, respiratory intensive care unit, resuscitation departments). Analysis with the support of literature in social sciences and humanities.
Results.– Several explanations of transfer difficulties, structural (notably a lack of beds in the upstream units) or linked to the confidence from the acute healthcare departments (anticipation of various "risks" at the PRM department level: turning back of the patient, tracheotomy and future dependency towards an artificial breathing apparatus, the question of active treatments limitation or cessation). A third level of explanation directly related to the patients' functional status: an a priori unfavourable opinion in case of cognitive impairment, especially for born-native pathologies, multiple sclerosis or brain injury in case of lack of perceived improvement since the admission in the PRM department.
Discussion.– Two essential findings appeared: a misunderstanding of the professional practice between PRM and acute healthcare units, in spite of common practices, and an imperfect perception of the patients' future by the upstream departments practitioners. A kind of disabled patient who could be transferred with difficulty was especially constructed in case of cognitive impairment within precisely defined pathologies. The final goal of our "action sociology" study is to make clearer the daily medical practices within the framework of emergency transfers of severely impaired patients in order to promote a renewed fluidity within our healthcare networks.

http://dx.doi.org/10.1016/j.rehab.2013.07.698

CO54-007-e

Premises of a care network for the orientation and rehabilitation of severe traumatic brain injury (TBI) patients in the Parisian area, France

A. Ruet [a,*], C. Jourdan [a], J.J. Weiss [b], P. Pradat-Diel [c]
[a] *AP–HP Hôpital Raymond-Poincaré, service de MPR, université de Versailles Saint-Quentin-en-Yvelines, EA4497, 104, boulevard Raymond-Poincaré, 92380 Garches France*
[b] *Centre ressource francilien du traumatisme crânien, France*
[c] *AP–HP, hôpital Pitié-Salpétrière, université Paris 6, France*
*Corresponding author.
E-mail address: alexis.ruet@gmail.com

Keywords: Care network; Traumatic brain injury; Neurosurgery

Objectives.– To improve rehabilitation care access for adult patients with TBI after discharge from neurosurgery in the Parisian area. To identify care possibilities according to patients' needs.
Material/patients and method.– Four-month follow up of severe TBI patients in three out of the six Parisian neurotrauma centres. Referral suggestions, discharge to neuro-rehabilitation, specialized follow-up consultations. Survey on regional neuro-rehabilitation centres, addressing care access provided to traumatic brain injured patients.
Results.– On 142 identified adult brain injured patients (76 traumatic brain injury, 43 subarachnoid hemorrhage), 73 were evaluated. All 25 severe traumatic brain injured patients discharged from neurosurgery were admitted in rehabilitation or guided toward specialized follow up. Ten "bed-blockers" accumulated 36 months of unjustified acute-care hospitalization.
Discussion.– Care pathways management for TBI patients in the Parisian area are complex, owing to the density of population, the emergency care organization, the important number of rehabilitation centres and the unfamiliarity of acute care practitioners with their specializations. Cognitive follow-up assessments are lacking. Interventions of dedicated medical staff aware of TBI patients in intensive care and neurosurgical units could improve follow-up quality. A specific care network would facilitate identification, evaluation, rehabilitation, and re-entry into society for brain injured adults in the Parisian area.

http://dx.doi.org/10.1016/j.rehab.2013.07.699

CO54-008-e

Periodic review of health for population with disabilities in Normandy preliminary results for 2012

F. Leroy [a], L. Foucher [b,*], V. Benard [c], C. Geslain [c], P. Lemagnen [d], L. Letenneur [e], S. Godefroye Hernoe [f]
[a] *CHU de Caen,, IRSA, CHU Côte-de-Nacre, 14033 Caen, France*
[b] *CHU de Caen, service de MPR, Caen, France*
[c] *IRSA, institut régional pour la santé, France*
[d] *RSVA, réseau des services pour la vie autonome, France*
[e] *MAS IKIGAI Bretteville l'Orgueilleuse, France*
[f] *IME Corentin-Donnard, Caen, France*